

Industrial Commission of Arizona



Staff Recommendations and Request for Public Comment
for
2015/2016 Arizona Physicians' and Pharmaceutical Fee Schedule

by

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The accompanying Excel file contains the following tables, which are referenced in this Staff Report:

Tables 1(A) and 1(B). Deleted 2014 and 2015 *CPT*®-4 Codes

Tables 2(A) and 2(B). Added 2014 and 2015 *CPT*®-4 Codes

Table 3. Anesthesia Codes and Anesthesia Conversion Factor (00100–01999)

Table 4. Surgery Codes (10021–69990)

Table 5. Radiology Codes (70010–79999)

Table 6. Pathology/Laboratory Codes (80047–89398)

Table 7. Medicine Codes (90281–96999)

Table 8. Physical Medicine Codes (97001–98969)

Table 9. Special Services Codes (99000-99607)

Table 10. Evaluation and Management Codes (99201–99499)

Table 11. Category III Codes (0019T–0380T)

I. INTRODUCTION

The information contained in this document are based, in part, on a review of the following documents: 1.) *Current Procedural Terminology* (“CPT®”) 2014 and 2015 Fourth Editions, American Medical Association (“CPT®-4”); 2.) *Relative Values for Physicians*, 2014 OptumInsight (Ingenix), 3.) *The Essential RBRVS 2015*, 1st Quarter Edition, Optum, and 4.) Fee schedules in effect on January 31, 2015, from the states of Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah and Washington.

This document includes recommendations to update the Fee Schedule to incorporate changes to the American Medical Association’s 2014 and 2015 editions of the CPT®-4, and setting values of new codes and selected codes from Anesthesia, Surgery, Radiology, Pathology/Laboratory, Medicine, Physical Medicine, Special Services, Evaluation and Management, and Category III.

It is important to note that this is a preliminary document that is intended to serve as a foundational document for public comment and future discussions that may arise during the public hearing process. Following the public hearing process, Commission staff will provide supplemental information to the Commissioners, including an analysis of the public comments received and staff recommendations. The Commissioners, at a later duly noticed public meeting, will take official action, which will be incorporated in the 2015/2016 Fee Schedule.

For copyright reasons, the Commission is not permitted to include in its Fee Schedule, the descriptors associated with five-digit CPT® codes.

II. RECOMMENDATIONS AND REQUEST FOR PUBLIC COMMENT REGARDING THE 2015/2016 PHYSICIANS' AND PHARMACEUTICAL FEE SCHEDULE

A. Statement of Issues Under Consideration

1. Methodology to Determine the Values of Codes Under Review.

The Commission surveys the workers' compensation fee schedules from the states of Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah, and Washington and uses the following methodology to calculate the reimbursement values for the codes under review:

- a. Current Arizona values between the 75th and 100th percentile of the states surveyed are not adjusted;
- b. Current Arizona values over the 100th percentile of the states surveyed are reduced to the 100th percentile; and
- c. Current Arizona values below the 75th percentile are increased to the 75th percentile subject to the following: Increases shall be capped at 25%, unless and except as necessary to bring a current value up to the 50th percentile.

The foregoing methodology does not apply to following:

- a. If the survey sample size is less than four, then the code may be identified as RNE (Relativity Not Established)¹ or BR (By Report)², except if it involves the professional component ("PC") of a value in which case the PC value may be based on the current ICA PC to Total Value ratio;
- b. Codes specific to Arizona, the value of which may be determined through the hearing process; and
- c. Codes otherwise designated as BR.

In response to an ongoing interest from the community to evaluate this issue and recommendations made last year from a Director's advisory committee that were adopted by the Commission, several changes have been implemented and are reflected in this year's staff report:

- Replacing the four year cycle of review, all codes have been reviewed this year. This task was performed by Commission staff rather than an outside vendor as considered last year. To facilitate this process, the form of reporting the codes and values has been changed to mirror how this information is presented commercially as well as by other states. This includes identifying codes that are "not covered" because they have not previously been adopted by the Commission

¹ RELATIVITY NOT ESTABLISHED (RNE) in the value column indicates a new or infrequently performed service for which sufficient data has not been collected to allow the assignment of a reimbursement value based on unit relativity. Additional information about the RNE designation is contained in the Fee Schedule introduction.

² BY REPORT (BR) in the value column indicates that the value of the service is to be determined "by report" because the service is too unusual or variable to be assigned a reimbursement value based unit relativity. Additional information about the BR designation is contained in the Fee Schedule introduction.

(e.g. maternity codes, pediatric codes, etc.). This also includes identifying, where applicable, the technical component of a value (“TC”). As part of this process, and to improve the clarity of the information presented, *CPT*® codes that contain explanatory language specific to Arizona will continue to be preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®-4 are preceded by an AZ identifier and numbered in the following format: AZ0xx-xxx.

For informational purposes, last year the Commission reviewed the following codes: Surgery Codes (40000 – 59899), Radiology Codes (70010 – 79999), Special Services Codes (99000 – 99607), Anesthesia Relative Value and Anesthesia Conversion Factor. Under the four year cycle of review, the following codes would have been reviewed this year: Surgery Codes 60000 – 69999, Pathology/Laboratory Codes, Category III Codes, and the Anesthesia Relative Value.

- The Fee Schedule has been updated to the 2015 *CPT*® (which became effective January 1, 2015). Because last year’s Fee Schedule adopted changes to the 2013 *CPT*®, updating this year’s Fee Schedule to the most recent *CPT*® edition required review of both the 2014 and 2015 editions of the *CPT*®.
- The review date of the fee schedules of other jurisdictions was changed to January 31, 2015.
- The Commission has awarded a contract to an outside consultant to perform a study to evaluate the impact of moving to an RBRVS based system. Subject to available funding, this study will be performed this year.

The Commission welcomes public comment on these changes.

2. Adoption of National Correct Coding Initiative Edits as published by the Centers for Medicare and Medicaid Services (“CMS”).

Over the past year, the Commission has received questions regarding the applicability of the National Correct Coding Initiative Edits (“CCI Edits”) to bills processed under the Fee Schedule. Because the CCI edits have not been adopted by the Commission, some payers have expressed an interest in having this issue considered.

According to information provided on CMS’s webpage for The National Correct Coding Initiative Edits, the CMS developed the CCI Edits to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association’s *CPT*® Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. Additional information about the CCI Edits is found at <http://www.cms.gov/NationalCorrectCodInitEd>

The Commission welcomes public comment on the issue of whether the CCI edits should be adopted.

3. Reimbursement for Participation in Peer Review as Described in the Evidence Based Treatment Guideline Process Approved by the Commission on December 18, 2014.

On December 18, 2014, the Commission adopted the recommendations of an advisory committee regarding the implementation of a process for the use of evidence based treatment guidelines. The process, which has not yet been implemented, includes a provision that allows a provider to bill a payer for time spent participating in an independent peer review described in the Administrative Review Section of this process. See Section III(K) of the process draft which can be viewed in its entirety at: http://www.ica.state.az.us/PublicNotices/DIRECTOR_EBM_Dir_Adv_Comm_on_EBM_Treatment_Guidelines_final_draft.pdf

The Commission welcomes public comment on whether an existing *CPT*® code (or codes) could be used (with, if necessary, Arizona specific language adopted to address the peer review provision found in the treatment guideline document described above) or whether an Arizona specific code should be adopted. Additionally, the Commission welcomes public comment on the reimbursement value that should be adopted for the corresponding code.

4. Designation of Medi-Span as the Publication for Purposes of Determining Average Wholesale Price (“AWP”).

Medi-Span® is the publication currently used for determining AWP under the Pharmaceutical Fee Schedule. Staff recommends that this publication continue to be used for this purpose. The Commission welcomes public comment on this issue

5. Adoption of Add-On and Modifier “-51” Exempt Codes.

The Commission has historically identified Add-On and Modifier “51” Exempt Codes in the Fee Schedule through the use of asterisks. One asterisk denotes add-on codes, while two asterisks denotes modifier 51 exempt codes. This information is contained in the *CPT*® adopted by the Commission and staff questions whether it needs to be separately stated in the Arizona Fee Schedule unless it is required with respect to an Arizona specific code. Therefore, staff is recommending that this designation be discontinued in the Fee Schedule as it is unnecessary. The Commission welcomes public comment on this issue.

6. Pharmacy Dispensing Fee for Non Prescription Medications.

Last year *U.S. HealthWorks* recommended that the Pharmacy Fee Schedule be changed to eliminate a dispensing fee for over the counter medications. At that time, the Commission took no action on the recommendation and advised that the issue would be considered this year to allow for public comment. The Commission requests public comment on this recommendation, along with any studies or practices that are

validated and accepted in the industry with respect to dispensing fees for over the counter medications.

7. Billing for Pharmaceuticals Dispensed by a Physician.

Last year the Commission declined to take action on requiring standardized billing for pharmaceuticals and advised that it would continue its review, which would include consideration of providing direction on how to bill for pharmaceuticals dispensed by a physician. Specific to this issue, *Progressive Medical PMSI* recommended that physician billing for pharmaceuticals include both the repackaged national drug code (NDC) and the original manufacturer NDC. If the Commission was not going to adopt a universal billing form (which the Commission declined to do last year), then *PMSI* recommended that the reporting of this multiple NDC information be done as follows: The original manufacturer NDC should be reported first, followed by the repackaged NDC. If a physician uses the CMS 1500 form (which is typically used by physicians), then this information could be provided, in that order, in the shaded upper portion of the service line(s) of that form (fields 24(a) through 24(g)). In addition to requesting public comment on this issue, the Commission also seeks public comment on whether, without mandating the use of a specific form, other information should be required when billing for a pharmaceutical, such as ingredient-level billing of compound drugs.

8. Deletion of Pathology Codes 80100, 80101, and 80104.

The Pathology and Laboratory guidelines contained in the 2014 Fee Schedule contain criteria for reimbursement for Pathology codes 80100, 80101 and 80104. These three codes are deleted in the 2015 *CPT®*, which means that the language found in the Pathology and Laboratory guidelines will also be deleted. The Commission seeks public comment of whether new language needs to be included in the Fee Schedule to replace the language that will be deleted.

B. Adoption of Deletions, Additions, General Guidelines, Identifiers, and Modifiers of the *CPT®*-4.

This document includes a review of deletions and additions to the *CPT®*-4. It is intended to conform the Fee Schedule to these changes that have taken place in the 2014 and 2015 editions of the *CPT®*-4. Staff is therefore recommending the adoption of the changes contained in Tables 1(A) and 1(B) and Tables 2(A) and 2(B), which are found in the accompanying Excel file.

Tables 1(A) and 1(B) contains a listing of the procedural codes deleted from the 2014 and 2015 editions of the *CPT®*-4 publication.

Tables 2(A) and 2(B) contains a listing of the procedural codes that have been added to the 2014 and 2015 editions of the *CPT®*-4 publication and which are recommended for adoption in the Fee Schedule. The recommended values associated with each code are based on a review of the workers' compensation fee schedules from the states of Colorado, Nevada, New Mexico, North Carolina, Oregon, Utah and Washington. The follow-up days

associated with identified services are taken from the 2015 *Relative Values for Physicians* published by OptumInsight (Ingenix).

Additionally, although the Commission is not permitted to include in its fee schedule the descriptors associated with five-digit *CPT*® codes, staff recommends that the Commission adopt by reference the terminology changes, including the general guidelines, identifiers, and modifiers of the *CPT*® codes to ensure that the 2015/2016 Fee Schedule is current and reflects the latest changes to the 2014 and 2015 editions of the *CPT*®-4. To the extent that a conflict may exist between the adopted portions of the *CPT*®-4 and a code or guideline unique to Arizona, the Arizona code or guideline shall control.

C. Updates to the Adopted *CPT*® Codes

All *CPT*® codes have been reviewed in this staff report (replacing the four year cycle of previous reviews). Staff is recommending the adoption of the changes contained in Tables 3 and 11, which are found in the accompanying Excel file.

As noted above, to facilitate the review process, the form of reporting the codes and values has been changed to mirror how this information is presented commercially as well as by other states. This includes identifying codes that are “not covered” because they have not previously been adopted by the Commission (e.g. maternity codes, pediatric codes, etc.). This also includes identifying, where applicable, the professional component (designated by modifier 26) and the technical component (designated by modifier TC) of a service.

Further, as part of this process, and to improve the clarity of the information presented, *CPT*® codes that contain explanatory language specific to Arizona will continue to be preceded by Δ. Codes, however, that are unique to Arizona and not otherwise found in *CPT*®-4 are preceded by an AZ identifier (which replaces the Δ identifier) and numbered in the following format: AZ0xx-xxx.

Lastly, the follow-up days associated with identified services are taken from the 2015 *Relative Values for Physicians* published by OptumInsight (Ingenix).